Special Terms and Conditions of Approval

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00117/4

TITLE: *Consumer Directed Care*: Florida Cash and Counseling Demonstration

AWARDEE: Florida Agency for Health Care Administration

The following are Special Terms and Conditions (STCs) for the Florida Cash and Counseling Demonstration, *Consumer Directed Care,* under a Medicaid Section 1115 Demonstration. These STCs incorporate the amendment to remove the "control/treatment group" experimental design and offer the demonstration statewide was as requested on December 23, 2002. The Special Terms and Conditions are arranged in eight subject areas: General Program Requirements, General Reporting Requirements, Legislation, Assurances, Operational Protocol, General Financial Requirements, Monitoring Budget Neutrality, and a Summary Schedule of Reporting Items.

Letters, documents, reports, or other materials that are submitted for review or approval must be sent to the Centers for Medicare & Medicaid Services (CMS) Central Office Demonstration Project Officer and the State representative in the CMS Regional Office.

I. GENERAL PROGRAM REQUIREMENTS

1. **Extension or Phase-out Plan.** The State will discuss demonstration extension plans with CMS at least 18 months prior to demonstration expiration, and requests for extensions are due to CMS no later than 12 months prior to the expiration of the demonstration. If the State does not request an extension, it must submit a phase-out plan, which includes provisions for cessation of enrollment, to CMS no later than 12 months prior to the expiration of the demonstration. The phase-out plan will be submitted for CMS to review and consider for approval.

2. **Cooperation with Federal Evaluators.** The State will fully cooperate with Federal evaluators and their contractor's efforts to conduct an independent Federally funded evaluation of the demonstration program.

3. **The CMS Right to Suspend or Preclude the Demonstration During Implementation.** The CMS may suspend or preclude State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the Special Terms and Conditions or other terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.

4. **The CMS Right to Terminate or Suspend the Demonstration During Operation.** During demonstration operation, CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with any of the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. The CMS reserves the right to withhold approval for the demonstration project or withdraw such approval at any time, if it determines that granting or continuing the demonstration project would no longer be in the public interest. If the demonstration project is terminated by action of CMS, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

5. **State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for suspension or termination, together with the effective date. If the demonstration project is terminated by the State, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

II. GENERAL REPORTING AND DATA REQUIREMENTS

(Attachment C provides a summary of the frequency of required reporting items.)

6. **Monthly Progress Calls.** The CMS and the State will hold monthly calls to discuss demonstration progress and the State will respond to questions and data requests from CMS regarding any issues. At such time CMS determines that the State has substantially complied with all Terms and Conditions, CMS and the State will hold quarterly calls.

7. **Quarterly & Annual Progress Reports.** The State will submit quarterly progress reports that are due 30 days after the end of each Federal Fiscal Year quarter. The quarterly report shall include a narrative description of demonstration progress and an accounting of participation, utilization, and budget neutrality status. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. The CMS reserves the right to request the annual report in draft.

   A. Report Narrative. The narrative portion of the reports must address, at a minimum:

   - A discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
   - A discussion of the State's progress in completing program changes identified in the Infrastructure Redesign Plan.
   - Notable accomplishments, including findings from Quality Assurance, beneficiary survey and evaluation activities; and,
   - Problems/issues that were identified and how they were solved.

   B. Financial Accounting. The State will construct and monitor a database that will be used to generate reports providing individual-level and aggregate data for all participants in the demonstration. The financial report should reconcile with CMS 64 reporting required by Attachment A. The database will consist of all participants in the demonstration, whether the individual was enrolled in the State's home and community based waiver (HCBW) or regular Medicaid personal care services program prior to enrollment in the demonstration. This database shall at a minimum include identifying information for all participants (name, address, social security number, telephone number), participation start date, the effective date a participant no longer receives cash, the actual participation stop date (i.e., date participant ceases receiving any Medicaid personal care services or HCBW benefits), an indication of whether the participant was assigned to either the randomized treatment group or control group or is a non-randomized "Choice and Control" participant, an indication of whether a participant was enrolled in the demonstration as a "new" client or a "current" client for purposes of calculating the new to current client enrollment ratio caps, aggregate monthly enrollment totals for each treatment group and the control group, total cash payments (by quarter) for those individuals within the treatment groups, and claim payment amounts (by quarter) for individuals within the control group for those services that would have been used as the basis for establishing cash payments had the participant been selected as a treatment group member.

Within 3 months from the date of amendment approval, the State will provide CMS with documentation of the prototype of the database that will be used to collect participant data and generate the financial accounting to be included in each quarterly report.

Within 6 months from the date of amendment approval, the State shall present documentation of a final operational database to CMS for approval. The documentation should at a minimum include:

- Evidence that the database is operational.
- Evidence that the database design and infrastructure satisfies all required data elements. Specifically, that the database can track individual-level data and transform the information into aggregate data for analysis of budget neutrality.
- Evidence that the database can produce the type of aggregate reports needed for monitoring budget neutrality. The State should provide sample reports to CMS for review.
- Documentation that all participating State agencies (Agency for Health Care Administration, the Department of Elder Affairs, the Department of Children and Families, and the Department of Health) have a cooperation agreement to collect, provide, and/or allow access to, on a timely basis, the participant information needed to populate the database.

8. **Final Report.** At the end of the demonstration, the State will submit a draft final report to CMS for review and comments. The final report with CMS' comments is due no later than 180 days after the termination of the project.

III. LEGISLATION

9. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter (of which these Special Terms and Conditions are part), will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

   If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

10. **Changes in Federal Law Affecting Medicaid Expenditures.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State Section 1115 Demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

    If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to CMS for complying with the change in law. If the methodology were consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

11. **Amending the Demonstration.** The State may submit for CMS consideration a request for an amendment to the demonstration to request exemption from changes in law occurring after the demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

IV. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance that the following will be met:

12. Voluntary Program. The program is voluntary for all demonstration participants.

13. Essential Elements of Self-Direction. As a state Medicaid program that presents individuals with the option to control and direct Medicaid funds through individual budgets, the State will meet the four essential elements CMS has determined is necessary to operate a successful self-directed program. The State will address in the Operational Protocol how it will satisfy the following elements:

- **Person Centered Planning.** A process, directed by the participant, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant.
- **Individual Budgeting.** The value of services and supports, as determined by a plan of care, under the control and direction of the participant.
- **Self-Directed Supports.** A system of activities (specifically supports broker services and financial management services) that assist the participant to develop, implement and manage services and supports.
- **Quality Assurance and Improvement.** A system that effectively assures the health and welfare of program participants and continuous improvement in the demonstration program. The system will at a minimum include criminal background checks at no cost to the participant, an individual and statewide emergency back-up plan, and an incident management system. The system will be operational within three months of implementation of this amendment.

CMS will provide technical assistance to the State on the specific program provisions required by the Essential Elements and will work with the State to determine the best methods and timeframes for operationalizing the Essential Elements.

14. Fiscal/Employer Agent. A Fiscal/Employer Agent will be available to all participants that choose or need one based on a skills test.

15. Evaluation. The State will conduct an evaluation of the program and will cooperate with an independent evaluation contractor CMS may procure.

16. Reporting of "New" to "Continuing". The ratio of "new" to "continuing" Medicaid personal care services or home and community-based waiver services clients who enroll in (i.e., join) the demonstration in the State of Florida may not exceed .40. NOTE: The "Choice and Control" treatment group is not subject to this requirement and will not count towards the "new" to "continuing" ratio cap.

17. **Public Notice Requirements.** The State will comply with public notice requirements as published in 59 Federal Register 49249, dated September 27, 1994 and CMS requirements regarding Native American Tribe consultation.

18. **Preparation and Approval of Operational Protocol.** The State will prepare an Operational Protocol Document, which represents all policies and operating procedures applicable to this demonstration, and will submit the Operational Protocol to CMS for approval prior to implementation. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval. *Requirements and required contents of the Operational Protocol are outlined in* Section V *of these Special Terms and Conditions.*

19. **Adequacy of Infrastructure.** This demonstration will provide adequate resources to support participants in directing their own care. The support assures, but is not limited to, participant's compliance with laws pertaining to employer responsibilities, provision for back-up attendants as needs arise, and the performance of background checks on employees and guidance to participants on the results of checks. Adequate resources for implementation, monitoring activities, and compliance to the terms and conditions of approval of the demonstration will be provided by the State.

20. **Infrastructure Redesign Plan.** The State will develop a quality improvement plan for administering and managing the program. The plan shall at a minimum include identification of the program areas for improvement, a description of how the area affects budget neutrality, the projected dollar amount the item contributes to the budget disparity, the proposed resolution, how the proposed resolution will affect the cumulative budget, and a timeframe for implementing the proposed resolution. The State has within 3 months from the date of amendment approval to present a plan to CMS.

    The State shall address the following programmatic areas in the Infrastructure Redesign Plan:
    - Development of participant purchasing plans in accordance with Medicaid utilization history;
    - Development of procedures for timely identification of inactive demonstration participants and the recoupment of unexpended Medicaid funds;
    - Implementation by the fiscal intermediary of an automated account monitoring and management system for financial monitoring and reconciliation of account balances;
    - Development of procedures and guidelines for managing undesignated account balances that reflect risk management and participant's authority to revise purchasing plans;
    - Development of appropriate guidelines for making adjustments to individual budgets;
    - Implementation of additional consultant and consumer training on the development and management of individual budgets; and
    - Development of a monitoring protocol for consultants to ensure appropriate uses of individual budgets and program integrity.

21. **Assistance of a Proxy.** This demonstration is designed to assist individuals who are capable of directing their own care. Individuals not capable of directing their own care will not be

deliberately excluded from participating in the demonstration. Specifically, persons who require the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative) will not be excluded from program participation.

22. **Supplant Services.** Cash payments provided under this demonstration program do not supplant informal care services that have routinely and previously been available to project participants. Such ongoing informal care services will be identified as a part of each participant's care plan.

23. **Contract Approval.** The Fiscal Intermediary (FI) contract(s) will be reviewed and approved by CMS prior to the State's requesting Federal financial payments for expenditures incurred under the contract(s).

V. OPERATIONAL PROTOCOL

24. Operational Protocol Timelines and Requirements. The Operational Protocol will be submitted to CMS no later than 90 days prior to program implementation. The CMS will respond within 60 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the terms and conditions of approval, those issues being necessary to approve the Operational Protocol.

Federal Financial Participation (FFP) is not available for Medical Assistance Payments prior to CMS approval of the Operational Protocol. The FFP is available for post-approval project development and implementation, and compliance with Special Terms and Conditions.

Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures, including changes to cost-sharing amounts or subsidy amounts, including adjustments for inflation, must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

25. Required Contents of Operational Protocol:

a. Organization and Structural Administration. A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform.

b. Reporting Items. A description of the content and frequency of each of the reporting items as listed in Section II and Attachments A and C of this document.

c. Essential Elements of Self-Direction. As stated in Term and Condition #13, a description of the processes in place to meet the four Essential Elements of Self-Directed Programs (person centered planning, individual budgeting, self-directed supports, and quality assurance and improvement).

d. Benefits. Descriptions or listings of:

- procedures for determining the plan of care;
- methodology for establishing the budget for the plan of care;
- how purchasing plans are developed;
- procedures and mechanisms to be used to review and adjust payments for the plan of care;
- services which will be cashed out; and,
- Alternative Health Related Services which may be approved for participants, as well as procedures for amending the list of services.

e. Outreach/Marketing/Education. A description of the State's outreach, marketing, education, and staff training strategy. NOTE: *All marketing materials must be reviewed and approved by CMS prior to use.* Included in the description:

- information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers);
- types of media to be used;
- specific geographical areas to be targeted;
- locations where such information will be disseminated;
- staff training schedules, schedules for State forums or seminars to educate the public; and,
- the availability of bilingual materials/interpretation services and services for individuals with special needs. Include a description of how eligibles will be informed of cost sharing responsibilities.

f. Eligibility/Enrollment. A description of the population of individuals eligible for the demonstration (and eligibility exclusions) and population phase-in and the following:

- eligibility determination;
- annual redetermination;
- intake, enrollment, and disenrollment;
- procedures for determining the existence and scope of a demonstration applicant's existing third party liability;
- the State agency that will be responsible for each of the above processes; and,
- a comparison of the number of new individuals accessing Medicaid-funded community based services to the numbers of individuals accessing Medicaid-funded community-based services without the demonstration.

g. Enrollment Ceiling. Description of the enrollment ceiling.

h. Quality. Description of an overall quality assurance monitoring plan that includes, but not be limited to the following:

- quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program;
- the mechanisms the State will utilize to assure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied, and that funds provided to these beneficiaries are used appropriately;
- the system the State will operate by which it receives, reviews and acts upon critical events or incidents, with a description of the critical events or incidents;
- case management staff for purposes of monitoring participant health and welfare;
- quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys;

- plans to report survey results, service utilization, and general quality assurance findings to CMS as part of the quarterly and annual reports;
- procedures for assuring quality of care and participant safeguards;
- procedures for insuring against duplication of payment between the demonstration, fee for service and Home and Community-Based Services programs; and fraud control provisions and monitoring.

h. Education, Counseling, Fiscal/Employer Agent and Support Services. Descriptions of the following topics will be included:

- the State's relationships and arrangements with organizations providing enrollment/assessment, counseling, training, and fiscal/employer agent services;
- the procurement mechanism, standards, scope of work and payment process for the fiscal/employer agent;
- procedures for ensuring sufficient availability of fiscal/employer agent services for participants who do not pass the mandatory test on employer responsibilities;
- procedures for mandatory testing of participants related to fiscal and legal responsibilities and training opportunities and support services available for participants of the demonstration who require assistance with their fiscal and legal responsibilities; and,
- the procedures for conducting participants background checks on potential providers and informing participants of the results of the criminal background checks.

i. Participant Protections: A description of the State procedures and processes to assure that protections are in place. The description will include the following:

- procedures to assure that families have the requisite information and/or tools to direct and manage their care, including but not limited to employer agent services such as training in managing the caregivers, assistance in locating caregivers, as well as completing and submitting paperwork associated with billing, payment and taxation;
- a viable system in place for assuring emergency back up and emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place;
- procedures for how the State will work with families who expend their individualized budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the continuation of the health and welfare of the individual are available;
- procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination; and,
- process by which the State makes available to participants, at no cost, provider qualification/background checks.

j. Evaluation Design. A description of the State's evaluation design. The description will include the following:

- discussion of the demonstration hypotheses that will be tested;
- outcome measures that will be included to evaluate the impact of the demonstration;
- what data will be utilized;
- methods of data collection;
- effects of the demonstration will be isolated from those other initiatives occurring in the State;
- any other information pertinent to the State's evaluative or formative research via the demonstration operations; and,
- plans to include interim evaluation findings in the quarterly and annual progress reports (primary emphasis on reports of services being purchased and participant satisfaction.)

k. Evaluating, Measuring, and Reporting New to Continuing Client Ratio. The ratio of "new" to "continuing" Medicaid personal care services or home and community-based waiver services clients who enroll in (i.e., join) the demonstration in the State of Florida may not exceed .40. **NOTE**: As stated in Special Term and Condition #16, the "Choice and Control" population is not subject to this requirement and will not count towards the "new" to "continuing" ratio cap.

ATTACHMENT A
GENERAL FINANCIAL REQUIREMENTS

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program and those provided under *Consumer Directed Care*: Florida Cash and Counseling Demonstration under Section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).

2. **a.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year (00…99) in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.

b. For each demonstration year, four separate CMS-64.9 Waiver and/or 64.9P Waiver forms should be submitted that report expenditures subject to the budget neutrality cap. On the first form, all expenditures for participants in the former "**Choice and Control**" program (subject to an enrollment limit of 150 adults with developmental disabilities, as defined in Attachment B, 3) shall be reported. On the second form, all expenditures for adults with physical disabilities (Traumatic Brain Injury/Spinal Cord Injury, **TBI/SCI Adult**) shall be reported. On the third form, all expenditures for adults and children with developmental disabilities (**Developmental Services**) shall be reported. And last, on the fourth form, all expenditures for the aged (**Aged/Disabled Adult**) shall be reported. The sum of these forms should represent the expenditures subject to the budget neutrality cap reported in that quarter. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.).

c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include Medicaid expenditures on behalf of demonstration participants. The services subject to budget neutrality include the following categories as they appear on the forms CMS-64.9 Waiver and/or CMS-64.9P Waiver: Home Health Services, Home and Community-Based Services, Personal Care Services, Targeted Case Management, Hospice Benefits, and Other Care Services (such as the subsets of Non-Emergency Transportation and Durable Medical Equipment).

d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. Procedures regarding the tracking and reporting of administrative costs will be described in the Operational Protocol to be submitted by the State to CMS under terms specified in Section V.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 Demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report content, and frequency must be discussed by the State in the Operational Protocol (see Section V).

3. For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of member/months for demonstration participants in each of the four demonstration populations. This information should be provided to CMS in conjunction with the quarterly progress report referred to in Term and Condition #7 of Section II. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section V).

4. The standard Medicaid funding process will be used during the demonstration. Florida must continue to estimate total matchable Medicaid expenditures for the entire program on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal Fiscal Year on the Form CMS-37.12 for both MAP and ADM. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2 c. of

this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS.

Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in the finalization of the grant award to the State.

5. The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

- **a.** Administrative costs, including those associated with the administration of the demonstration.
- **b.** Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
- **c.** Net medical assistance expenditures made under Section 1115 Demonstration authority, including those made in conjunction with the demonstration.

6. The State will certify State/local monies used as matching funds for the *Consumer Directed Care* program and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT B

MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

A budget model has been developed for each demonstration population within the *Consumer Directed Care* demonstration. The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period.

1. "Choice and Control" Population

a. The "Choice and Control" group is subject to an enrollment limit of 150 developmentally disabled adults who were participants in the former "Choice and Control" program, a state-only "cash and counseling-like" program that operated in a 14-county geographic area that did not offer *Consumer Directed Care* to developmentally disabled adults. The limit for "Choice and Control" treatment group expenditures will be determined using a per capita cost method (described below) and monitored separately under the demonstration. By placing the State at risk for the per capita costs of the 150 Medicaid eligibles, CMS assures that "Choice and Control" treatment group expenditures do not exceed the levels that would have been realized had there been no demonstration amendment.

b. Service expenditures will be projected using a per capita cost method. Each demonstration year budget estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost (MPPC) times the actual number of member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3. The MPPC for each Demonstration Year (DY) is based on the actual cost experience of the "Choice and Control" participants and is trended forward based on the State's projected MPPC growth of 3 percent per year. The trended costs by DY are the following:

Demonstration Year	Time Period	Trended Monthly Per Person Cost
DY 2003	3/01/02 – 02/28/03	$ 1,972.91
DY 2004	3/01/03 – 02/28/04	$ 2,032.10
DY 2005	3/01/04 – 02/28/05	$ 2,093.06
DY 2006	3/01/05 – 02/28/06	$ 2,155.85
DY 2007	3/01/06– 02/28/07	$ 2,220.53
DY 2008	3/01/07– 02/28/08	$ 2,287.15

c. For the purpose of calculating the overall expenditure limit for the "Choice and Control" group, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an overall expenditure limit for the entire demonstration period. The Federal

share of this estimate will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

2. Non "Choice and Control" Participants

a. All other *Consumer Directed Care* participants will be eligible under one of three demonstration populations: adults with physical disabilities, adults and children with developmental disabilities, and aged. Each population is subject to the following enrollment cap for a cumulative enrollment limit of 3350 non "Choice and Control" participants.

Population	Enrollment Cap
Developmental Services population (adults and children with developmental disabilities)	2182
Traumatic Brain Injury/Spinal Cord Injury population (adults with physical disabilities)	39
Aged/Disabled Adult population (aged and adults with physical disabilities)	1129

The State will be at risk for all current treatment and control group participants, irrespective of whether the individual chooses to remain in *Consumer Directed Care* or transition into a traditional Medicaid program. By placing the State at risk for the per capita costs of all current treatment and control group participants, CMS assures that group expenditures do not exceed the levels that would have been realized had there been no demonstration.

b. The State will continue the ratio of "new"-to-"continuing" Medicaid personal care services or home and community-based waiver services clients who enroll in (i.e., join) the demonstration, which may not exceed .40. The ratio of new-to-continuing clients will be enforced on an annual basis. "New" clients will be defined as Medicaid eligibles that, regardless of whether or not they were already enrolled in the Medicaid program, began receiving Medicaid-financed personal care services upon enrollment in the demonstration. "Continuing" clients are defined as those who were already receiving Medicaid-financed personal care services or home and community-based waiver services prior to enrolling in the demonstration (i.e., received services within the 12 months preceding enrollment).

The State and the evaluation contractor will monitor the ratio of new-to-continuing clients enrolled in the demonstration every three months. If the maximum ratio of new-to-continuing clients exceeds the limit at these monitoring points, the State will cease enrolling new clients until the ratio of new-to-continuing clients returns to the level of .40 or less. If Florida exceeds the maximum ratio of new enrollees to continuing users at the end of the first year of enrollment, HHS may choose to end the demonstration. If Florida continues enrollment during the second year of the demonstration and exceeds the maximum ratio at the end of the second year of enrollment, HHS may choose to end the demonstration.

d. For each population, service expenditures will be projected using a per capita cost method. Each demonstration year budget estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost (MPPC) times the actual number of member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3. The MPPC for each Demonstration Year (DY) is based on the actual cost experience of each demonstration population and is trended forward based on the 2004 President Budget's projected annual MPPC growth of 8.1 percent per year for the disabled population and 6.5 percent per year for the aged population. The trended costs by DY for each population are the following:

Developmental Services Population (adults/children with developmental disabilities)

Demonstration Year	Time Period	Monthly Per Person Cost Trended @ 8.1%
DY 2004	3/01/03 – 02/28/04	$ 2,347.07
DY 2005	3/01/04 – 02/28/05	$ 2,538.96
DY 2006	3/01/05 – 02/28/06	$ 2,746.41
DY 2007	3/01/06– 02/28/07	$ 2,970.65
DY 2008	3/01/07– 02/28/08	$ 3,213.06

Traumatic Brain Injury/Spinal Cord Injury Population (adults with physical disabilities)

Demonstration Year	Time Period	Monthly Per Person Cost Trended @ 8.1%
DY 2004	3/01/03 – 02/28/04	$ 2,426.41
DY 2005	3/01/04 – 02/28/05	$ 2,624.49
DY 2006	3/01/05 – 02/28/06	$ 2,838.61
DY 2007	3/01/06– 02/28/07	$ 3,070.07
DY 2008	3/01/07– 02/28/08	$ 3,320.29

Aged Population (aged/adults with physical disabilities)

Demonstration Year	Time Period	Monthly Per Person Cost Trended @ 6.5%
DY 2004	3/01/03 – 02/28/04	$ 1,015.33
DY 2005	3/01/04 – 02/28/05	$ 1,082.77
DY 2006	3/01/05 – 02/28/06	$ 1,154.60
DY 2007	3/01/06– 02/28/07	$ 1,231.10
DY 2008	3/01/07– 02/28/08	$ 1,312.57

Revising the Trended Monthly Per Person Cost

The CMS adjusted the trended monthly per person cost in the budgets for the Traumatic Brain Injury/Spinal Cord Injury population, the Developmental Services population, and the Aged/Disabled Adult population to reconcile a $4,442,208.00 budget disparity between the current control and treatment group. The CMS will reconsider the $4,442,208.00 adjustment, within one year of implementing this amendment, pending the State's submission of data that shows that under the randomized budget model, the treatment group costs did not exceed control group costs or did not exceed the control group costs to the amount originally estimated. If the State does not submit data or fails to submit sufficient data to determine a new MPPC that reflects a positive budget trend, the MPPC included in these Terms and Conditions will be in effect until the scheduled expiration of this demonstration approval, February 28, 2008.

The State, when requesting revision to the MPPC, must provide the following information to allow CMS to conduct a sufficient budget analysis:

- For each demonstration year (2000-2003), Medicaid expenditures (as required in Attachment A, 2c) and participant member months for all individuals randomized into the demonstration, split-out by control and treatment group.
- Documentation that Medicaid expenditures for each year corresponds with CMS 64 reporting for that particular year. (**NOTE**: If the total Medicaid expenditures for each demonstration year do not correspond with CMS 64 reports, the State must correct CMS 64 reports for that particular demonstration period.)
- Explanation of any recoupments or offsets against expended Medicaid funds. Identify the dollar amount recouped/offset and the demonstration year to which adjustments were made.
- Documentation of the correction action systems the State has in place or intends to implement to assure that another such budget disparity will not occur.

If the CMS review of the data results in a justification to revise the MPPC, CMS will process the determination to revise the MPPC under the guidelines of these Terms and Conditions. The revised MPPC will be documented in the Operational Protocol and will become part of these Terms and Conditions. The State also has the right to request an amendment of the enrollment limit. However, removal of the enrollment cap is not within the scope of these Terms and Conditions and will be processed through the formal CMS Section 1115 clearance process.

Impermissible DSH, Taxes or Donations
The CMS reserves the right to adjust the budget neutrality ceilings to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda or regulations. The CMS reserves the right to make adjustments to the budget neutrality caps if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

How the Limit will be Applied
The limit calculated above will apply to actual expenditures for long-term care services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the approved 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review
The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual cumulative expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Demonstration Year	Cumulative target definition	Percentage
Year 1 - DY 2001	Year 1 budget estimate, plus	8 percent
Year 2 - DY 2002	Years 1 and 2 combined budget estimate, plus	3 percent
Year 3 - DY 2003	Years 1 through 3 combined budget estimate, plus	1 percent
Year 4 - DY 2004	Years 1 through 4 combined budget estimate, plus	0.5 percent

Extended Years:

Demonstration Year	Cumulative target definition	Percentage
Year 5 - DY 2005	Years 1 through 5 combined budget estimate, plus	0.5 percent
Year 6 - DY 2006	Years 1 through 6 combined budget estimate, plus	0.5 percent
Year 7 - DY 2007	Years 1 through 7 combined budget estimate, plus	0.5 percent
Year 8 - DY 2008	Years 1 through 8 combined budget estimate, plus	0.0 percent

ATTACHMENT C

SUMMARY SCHEDULE OF REPORTING ITEMS

Item	Timeframe for Item	Frequency of Item
Monthly Conference Calls	Prior to demonstration implementation and until CMS determines quarterly monitoring calls are sufficient.	Monthly progress calls with CMS and the State.
Operational Protocol	Due to CMS 90 days prior to implementation, CMS comments 30 days prior to implementation, and State completion/CMS approval prior to implementation.	One Operational Protocol. Changes to the Operational Protocol must be submitted and approved by CMS.
Quarterly/Annual Progress Reports	Due to CMS 30 days after the end of a Federal Fiscal Year quarter.	One quarterly report per Federal Fiscal Year quarter during operation of the demonstration; the report for the fourth quarter of each year will serve as the annual progress report.
Final Report	Due to CMS 180 days after the end of the demonstration.	One final report.